# Arkansas State Board of Nursing

**University Tower Building**
**1123 South University Avenue, Suite 800**
**Little Rock, Arkansas 72204**

**PHONE 501.686.2700**
**FAX 501.686.2714**
**www.arsbn.org**

## SPECIAL ACCOMMODATION INFORMATION FOR NCLEX® EXAM

**SPECIAL ACCOMMODATION INFORMATION**

In compliance with the Americans with Disabilities Act (ADA) of 1990, the Arkansas State Board of Nursing (ASBN) provides reasonable accommodations for candidates with disabilities that may interfere with their performance on the National Council Licensure Examination for Registered Nurses (NCLEX-RN®) or the National Council Licensure Examination for Practical Nurses (NCLEX-PN®).

Disability is defined in the American Disability Act with respect to an individual as a "physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment." Major life activities in general, include, but are not limited to, "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working."

**GENERAL INFORMATION**

An applicant that is requesting special accommodations for testing shall provide all required documentation to the Arkansas State Board of Nursing (ASBN).

To facilitate review of the request, an applicant should submit the request form and required documentation at the onset of the application process and prior to registration for the National Council Licensure Examination (NCLEX®). A decision regarding a special accommodation request may be delayed in the event that additional documentation is needed for verification and subsequently applicant testing may be delayed.

Once ASBN has received all of the required documents, including the Special Accommodation Request Form, Professional Documentation of Disability Form, and the Nursing Program Verification Form, the request will be reviewed and the applicant will be notified regarding the decision.

Do not schedule an appointment to take the NCLEX until receipt of confirmation from ASBN that special accommodations have been approved. For additional information refer to the NCLEX Examination Candidate Bulletin at www.ncsbn.org, regarding Testing Accommodations.

**TESTING CENTERS**

An approved applicant for special testing accommodations must schedule through the NCLEX Accommodations Coordinator via the phone number identified on the Authorization To Test (ATT) letter. No walk in testing is permitted.

To identify testing center locations please visit the National Council of State Boards of Nursing (NCSBN) web site at: https://www.ncsbn.org/1267.htm. Additional testing center information is located on the ASBN website at www.arsbn.org. Click on the Education tab and follow the NCLEX Exam Link to Testing Centers and Locate Test Center.

**REQUIREMENTS**

An otherwise qualified applicant may receive special accommodations for testing if all required documentation is provided. Identified documentation shall be mailed to the ASBN address, Attention: Education Department; no faxed or emailed copies are permitted.

1. **Special Accommodation Request Form**
   This form is completed by the applicant requesting special accommodations for taking the NCLEX. Submit complete Special Accommodation Request Form to ASBN. Complete all areas legibly.
2. **Professional Documentation of Disability Form**
   This form is completed by a qualified diagnostician with expertise in the area of the applicant's diagnosed condition to support the request. The applicant may be required to sign a waiver for release of information to ASBN. The form must contain complete information that includes all of the following:
   a) Report conducted within the last two years,
   b) Specific diagnosis included in the Diagnostic and Statistical Manual of Mental Disorders (DSM),
   c) Specific standardized test scores, interpretation of the scores and evaluations, and
   d) Recommendations for testing accommodations with stated rationale as to necessity and appropriateness for the diagnosed disability.
3. **Nursing Program Verification Form**
   Submit this form to the disability coordinator, dean or director of the nursing program attended for completion. The disability coordinator, dean or director should complete all areas (*Print except if directed otherwise*) and submit to the Arkansas State Board of Nursing, Attention: Education Department. The applicant may be required to sign a waiver for release of information to ASBN.

# ARKANSAS STATE BOARD OF NURSING

**UNIVERSITY TOWER BUILDING**
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## SPECIAL ACCOMMODATION FOR NCLEX® EXAM REQUEST FORM

**Directions:** Complete all areas (*print except if directed otherwise*) and submit to the Arkansas State Board of Nursing at the above address, Attention: Education Department

Full Name _____
FIRST MIDDLE MAIDEN LAST

Mailing Address _____
STREET CITY STATE ZIP

Social Security Number _____ E-mail Address _____

Telephone Number (___) _____ (___) _____ (___) _____
WORK HOME CELL

Expected Date of Graduation (Day/Month/Year) _____

Name of Nursing Program _____

Address of Nursing Program _____
STREET CITY STATE ZIP

Program Type *(check one)*

- ☐ Practical Nursing
- ☐ Registered Nursing-Diploma
- ☐ Registered Nursing-Associate
- ☐ Registered Nursing-Bachelor's

Examination Type *(check one)* ☐ *NCLEX-PN®* ☐ *NCLEX-RN®*

Test Center Where You Plan to Test _____

Diagnosis _____

Explain the nature and extent of your disability and how it will affect your ability to take the NCLEX

_____

_____

_____

_____

Identify the specific accommodations that you are requesting for consideration _____

_____

_____

Describe testing accommodations that you have been provided in the past, if any _____

_____

_____

Applicant Full Signature *(Do Not Print)* _____ Date _____

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## NURSING PROGRAM VERIFICATION

**Directions:** This form should be completed by the disability coordinator, dean or director of the nursing program where the applicant attended. Complete all areas *(Print except if directed otherwise)* and submit to the Arkansas State Board of Nursing at the above address, Attention: Education Department

Full Name _____
FIRST MIDDLE MAIDEN LAST

Social Security Number _____

Examination Type *(check one)* ☐ *NCLEX-PN®* ☐ *NCLEX-RN®*

1. Identify detailed diagnosis and accommodations that were provided while applicant attended the nursing program.

_____

_____

_____

_____

_____

2. Describe the types of examinations administered and the testing modifications that were provided for the above applicant while attending your nursing program.

_____

_____

_____

_____

_____

### NURSING PROGRAM VERIFICATION

Name of disability coordinator, dean or director _____
FIRST MIDDLE LAST

Name of Nursing Program _____

Address of Nursing Program _____
STREET CITY STATE ZIP

Telephone Number (___) _____
WORK

Signature (Do Not Print) _____ Date _____

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## PROFESSIONAL DOCUMENTATION OF DISABILITY

**Directions:** This form should be completed by the qualified diagnostician with expertise in the area of applicant's diagnosed condition. Complete all areas *(print except if directed otherwise)* and submit to the Arkansas State Board of Nursing at the above address, Attention: Education Department

Full Name _____
FIRST MIDDLE MAIDEN LAST

Social Security Number _____

Examination Type *(check one)* ☐ *NCLEX-PN®* ☐ *NCLEX-RN®*

### INFORMATION FOR PROFESSIONAL EVALUATOR

The identified applicant is requesting special accommodations for testing on the National Council Licensure Examination (NCLEX®). This examination consists of multiple choice questions, and alternative item format questions including but not limited to multiple-response items that require more than one response, fill-in-the-blank items, ordered responses, and recognition of audio items.

### REQUIRED INFORMATION *(please attach additional pages as needed)*

1. Describe the applicant's specific diagnosis of the disability (e.g. mental, learning, physical), including the date of initial diagnosis and respective DSM code. _____

2. Identify the specific standardized and professionally recognized adult assessment administered (such as Woodcock-Johnson, Wechsler Adult Intelligence Scale), date of assessment, the scores resulting from testing, and interpretation of the scores and evaluations. _____

3. Identify recommendations for testing accommodations with stated rationale as to necessity and appropriateness for the diagnosed disability. _____

Name of Professional _____
FIRST MIDDLE LAST

Address _____

Title _____ Telephone Number _____

Type of Professional License or Certification and Number _____ Expiration Date _____

Signature _____ Date _____